

PARRY (J. S.)  
DUP TWO LECTURES

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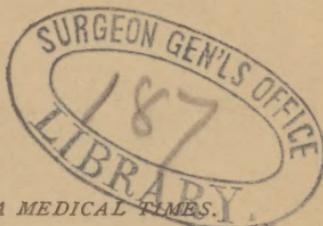
INHERITED SYPHILIS.

BY

JOHN S. PARRY, M.D.,

One of the Attending Accoucheurs to the Philadelphia Hospital, etc.

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# INHERITED SYPHILIS.

## LECTURE I.

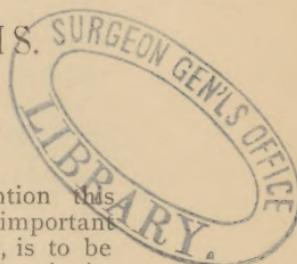
GENTLEMEN: I shall call your attention <sup>this</sup> morning to inherited syphilis; a very important subject, because the disease is very frequent, is to be met with in all classes of society, is protean in its forms, and must often be recognized and treated under the most embarrassing circumstances. The moral and social questions connected with the disorder make it necessary for you to be perfectly familiar with its peculiarities, for the peace and well-being of families will often depend upon your decisions. See to it, then, that you are sufficiently well informed to furnish reliable and truthful opinions upon the subject. See to it that you do not hereafter disturb domestic happiness by untimely statements or errors in diagnosis.

This hospital is very rich in illustrations of this disease, and I shall avail myself of the opportunity of showing you some very interesting cases this morning; but I want to say in the beginning that I have not at present the material to illustrate all the different varieties of the disease, while the wards happen to be very well supplied with examples of some of the late lesions of the affection.

The history of the first patient whom I shall show you is as follows:

*Case I.*—J. W., æt. 2 months. In 1865 his mother had primary, followed by constitutional, syphilis, which she did not contract from her husband, who has always been a healthy man, and who was at that time away from home. She has had no severe tertiary manifestations. Her body is covered with scars of a previous skin-eruption, but she has not suffered from any acute symptoms for more than a year. Excepting with this child, she has not been pregnant since she contracted the disease.

He was born March 29, and at this time weighed nine pounds and two ounces, and appeared to be healthy in every



particular. When two weeks old he began to suffer from "a cold in his head," and when four weeks old a mottled eruption appeared over his thighs and buttocks. This gradually spread to the trunk and legs. Since then it has never disappeared.

*Present condition, June 4, 1872.*—He appears to be fairly nourished, is quite fat, but his muscles are rather flabby. He is suffering from persistent though not severe coryza. The lips are not fissured. Over the forehead and upper part of the cheeks is a faint dark-colored mottled eruption. On the lower inner part of the cheeks and the chin the skin is "bistre-colored," or has the appearance of being stained by a solution of some dark-brown substance. The arms and upper part of the trunk are covered with obscure copper-colored spots. The eruption is best developed upon the buttocks and lower extremities, where there are numerous copper-colored, squamous spots, round or oval in shape, from a few lines to a quarter of an inch in diameter, and but slightly if at all elevated above the surface. The palms of the hands and the soles of the feet are perfectly healthy. There are no mucous patches anywhere.

His general health is moderately good, though he is rather irritable and suffers a good deal from diarrhoea, the discharges being green and mucous.

There are several points in this case that I hope you have noticed as I read the history. These are the fact that the disease has developed itself in an unequivocal manner in a child whose mother at the time of conception and during her gestation was not suffering from progressing constitutional syphilis; and the occurrence of coryza, followed by a scaly eruption, in a child who at birth was very healthy and weighed more than newborn infants ordinarily do. I remember seeing this boy in the wards the day after his birth, and, as I did not then recollect that the mother had had venereal disease, I did not think of his being infected by this poison. This is not an uncommon history; and you must not think that syphilitic children are always born with the marks of the disease upon them. On the contrary, the opposite is more frequently the case; and of the children that we see here, many of them appear to be plump and hearty at birth, and do not present that old, weazened appearance which has been described by some authors.

You have heard the account of the coryza by which he has been affected. This is one of the earliest, if not the very first, of the symptoms of the disease in a majority of the cases. It is likely to attract the attention of the mother at an early period, because coryza, which is of little importance in older children and adults, interferes so much with the nursing of young infants that in them it becomes very important, and demands the care of the physician. In this instance it has not been at all severe.

Certain important symptoms of congenital syphilis have not been developed in this child. In many or most cases of the disease, peculiar and very characteristic lesions of the mucous orifices follow the coryza of which we have been speaking, so that we often find it associated with linear fissures at the orifices of the nose, and upon the lips. These are comparatively superficial, have red bases, from which blood oozes, or they are covered with dry brown crusts. They radiate from the corners of the mouth, nostrils, and sometimes from the external angles of the eyes. When they are well developed and are associated with coryza, they form such a characteristic picture that the experienced physician can determine the nature of the affection at a glance. When these lesions have healed, they often leave permanent linear cicatrices,—a fact which it is well to remember, as these are so peculiar as to be very valuable in the diagnosis of late syphilitic manifestations, the nature of which may be doubtful. I say these symptoms have not been developed in this and some of the other children whom I shall show you.

The cutaneous eruption in this instance is squamous, and you see that it has a distinct copper hue. In addition to this, I ask you to notice the peculiar discoloration of other portions of the skin. You notice that the lower portion of the face especially is dark, and has a stained appearance. The peculiarities are not easily described, but the color has been compared to that of bistre, or staining from weak coffee. This appearance has been described by Trousseau (*Clin. Med.*, vol. iv., Philadelphia, 1871), who believes it to be pathognomonic of the disease which we are discussing. I consider it a most valuable sign; and, although it is imperfectly developed in this case, the appearance is

sufficiently characteristic to lead an experienced physician to suspect this child to be the victim of congenital syphilis.

In some cases, instead of having a squamous syphilitide, such as is present in this child, the eruption consists of bullæ,—pemphigus, as it is termed in the books.

My own experience would lead me to conclude that this form of skin-eruption occurs in those cases in which the disease manifests itself very soon after birth. It usually appears within a few days or weeks after the commencement of extra-uterine existence. My experience has also gone to show that it is only present in those cases in which the cachexia is profoundly developed; and, while pemphigus is a very important, it is not a very common eruption in inherited syphilis. Some authors have gone so far as to look upon all cases of infantile pemphigus as very suspicious, and as nearly always having a specific origin. Indeed, I am not sure but that a few good authorities say that it always has. I am very positive that this is not true, for it has been my fortune to meet with many cases of infantile pemphigus; and if I were to draw a conclusion from what I have myself seen, I would say that no variety of skin-disease is more frequent than this among children between one and fifteen months old. But I presume that my experience has been somewhat peculiar, for I have seen pemphigus sweep through the wards of this hospital, upon two separate occasions, almost like an epidemic. But at these times it presented well-marked and very important characters. The eruption was very constant in its seat, being located upon the neck, chest, and back, while it appeared but rarely upon the extremities, *and, if at all, never upon the palms of the hands or the soles of the feet.* This I conceive to be the important distinction between specific and non-specific pemphigus. The former in the majority of cases attacks the palms of the hands and soles of the feet, and is nearly always confined to these parts. If you meet with this bullous eruption limited to these locations in young infants, you are justified in suspecting that they are the subjects of inherited syphilis. According to my own belief, it would amount almost to a positive conclusion.

In certain rare cases, specific pemphigus first makes

its appearance upon other parts of the body. I have met with a few such, and in all of them the disease existed at birth or set in immediately after it. In one instance it appeared upon the face at the end of the first twenty-four hours, and spread very rapidly. Of these infants, those who were born alive perished in a short time; and, indeed, out of all the cases of specific pemphigus which I have seen, I cannot now recall one who lived beyond a few months, while most of them succumbed within a few days or weeks. I have previously hinted that it occurs in those who have inherited a severe form of the disease,—those whose systems are thoroughly saturated with the syphilitic poison. For this reason the prognosis of specific pemphigus is very serious,—a statement which is but a reiteration of a common opinion. I believe that all authors agree in regard to this point.

In the patient who is now before you, the disease seems to have commenced about a week after birth, but there were no positive symptoms of it until the child was about four weeks old. This is not uncommon, and inherited syphilis usually makes its appearance within the first three months of life. Of Diday's frequently-quoted cases, the affection commenced in 86 out of 158 children before the termination of the first month. But this is not a rule to which we find no exceptions. Some time since, I showed the class an infant over a year old, whose mother had suffered severely from a constitutional disease, and who then had for the first time a mild syphilitic eruption upon the trunk. I have also seen several cases in which the first symptoms were noticed much later than this,—in the third year of life. One of these I shall show you presently.

By what you see in this child, and from what I have already said, you have learned that the first symptoms of inherited syphilis are analogous to, and must be compared with, those of the secondary stage of acquired syphilis in adults. I think, too, that my experience in this hospital goes to show that just in proportion as the appearance of these is delayed until a remote period after birth, will they be mildly developed. In some instances they are so mild as to escape observation, or else they are not developed at all. I have reported such a case

in the *Photographic Review* for February, 1871, and I shall now bring another one before you.

*Case II.—Inherited Syphilis without the History of Secondary Symptoms; Severe Tertiary Lesions.*—E. H., æt. 8 years. Her parents have had six children, of whom this one is the third. Of these only the eldest and our patient are now alive. The former is a healthy girl. The second child died early in its second year, of summer-complaint. The last three children are all dead, having perished within a few weeks after birth. Her father died four years ago, of haematemesis. His wife says that he never had syphilis in any form, but that she was suffering from the disease at the time she conceived this child. Four months after her birth, tertiary symptoms appeared, and she had nodes on various parts of the body. In the middle of 1870 she was the subject of active and severe tertiary syphilis.

At her birth this child was perfectly well. She continued so until she was a month old, when an abscess formed on the back. This appears to have been the result of a contusion which she received at the time. From this time until she was two years old she continued well, so far as her mother was aware. Her mother denies that she ever had any symptoms of the disease with which she is now affected. She was then attacked by infantile paralysis, which presented the ordinary characters of the disease. Five or six months after the occurrence of the paralysis she began to suffer from convulsions. These were preceded by hard, painful swellings upon different portions of the head, but especially upon the forehead, where suppuration finally occurred. This was accompanied with enlargement of the lymphatic glands of the neck. She was relieved by treatment, and remained pretty well until she was four years old, when she had nodes upon the upper part of the tibia, the backs of the hands, and the frontal bone. These were accompanied by cutaneous ulcers.

When she was five years old, February, 1869, she was admitted to this hospital, suffering severely from these symptoms. Shortly afterwards a node appeared at the outer condyle of the left humerus, and gradually increased until there was swelling of the whole elbow, with slight synovial effusion. From then until now she has suffered severely from repeated outbreaks of tertiary symptoms. Two years ago, otorrhœa, with which she had been affected at intervals, reappeared, and has continued ever since. Nine months ago she had an attack of interstitial keratitis, which has left the cornea of the left eye hazy. Two weeks ago she complained for the first time of sore throat, and with this she began to discharge

offensive purulent matter from the nose and pharynx in considerable quantities.

*Present condition, June 5, 1872.*—Pale and very anaemic. On forehead, in median line, is a depressed white scar, from which pieces of frontal bone were removed by Dr. Duer, last fall. There is a slight opacity of left cornea from a previous attack of keratitis. (Right eye lost in infancy.) Copious and very offensive, thick, purulent discharge from nostrils. Teeth small, upper central incisors imperfectly developed and slightly notched; but, though suspicious, they are not characteristic. Upon inspecting the throat, thick, yellow, and very fetid pus is seen running from the posterior nares into the pharynx. Upon the half-arches are superficial sloughing ulcers. She has a copious discharge of pus from the left ear. At various points upon the surface of the body are the cicatrices of previous eruptions and ulceration. She now has substernal tenderness, and there are rapidly advancing nodes on each tibia.

I hope that you have been fully impressed by the salient points in this case. The syphilitic origin of the disease is undoubted; but, carefully as I sifted the history, I could not learn that she had ever suffered from any of the ordinary secondary symptoms, while, as you notice, she had nodes upon the forehead when she was two years and a half old, and these were followed by a similar lesion on the extremities. I have had an opportunity of watching these swellings run their course, and they have all the characters of the nodes of acquired syphilis. Indeed, you can prove this for yourselves by examining those at present on the tibia. It is asserted by Mr. Hutchinson (*Diseases of the Eye and Ear in Inherited Syphilis*, 8vo, London, 1863, p. 216) that the nodes of inherited syphilis first affect the lower part of the humerus. I have now under my care a patient in whom the first bone-disease was in this part, but in this child the forehead was first involved; and I should certainly say, from the cases which I have seen in this hospital, that the forehead and tibia are as likely as the humerus to be primarily affected. But the most interesting point in the case is the alleged absence of secondary symptoms. Some syphilographers, I know, doubt the correctness of such histories as this one. I have already alluded to another which I published in the *Photographic Review* for February, 1871. In that instance

the disease appears to have been transmitted from the father, and the child remained well until she was two years and nine months old, when nodes appeared on the tibia, and rapidly produced destruction of the bone. The illustration accompanying the history of that case shows that the disease of the osseous system was of no ordinary severity. Indeed, I do not remember to have ever seen it greater in any of the many and terrible examples of acquired syphilis that I have had the opportunity of examining. The only authority, so far as I am now informed, who acknowledges that these tertiary lesions of hereditary syphilis may be thus tardy in their appearance, and not be preceded by primary or secondary symptoms, is Melchior Robert (quoted by Lancereaux, Treatise on Syphilis, New Syd. Soc. ed., vol. i. p. 166). Of his opinion Lancereaux says, "This interpretation may appear hazardous." There is evidently much difficulty in arriving at the truth, and I must confess that I have grave doubts about the secondary symptoms not having preceded the tertiary in this and other similar cases. They may be so mild as to escape the notice, not only of the mother, but also of the physician. Allow me to illustrate this. I alluded a moment ago to the infant in whom the first symptoms of the disease made their appearance when the child was over a year old. I speak positively about that child, for my colleague, Dr. Maury, was kind enough to give me his opinion in regard to him. The mother had been severely affected by constitutional syphilis, the skin being covered with scars, the cicatrices of nodes appearing over the superficial bones, and the hard palate and bones of the nose being totally destroyed. At the time of her conception, and during the whole of her gestation, there were no active symptoms, but, on the contrary, she thought she had recovered perfectly. Seeing that she had been so profoundly affected, I watched the child with great interest. There were absolutely no signs of the inherited disease until the period spoken of, when he had a sparse, poorly developed, scaly eruption upon the lower part of the abdomen, the buttocks, and thighs. At this time he was little less than an infant Hercules, and I could hardly convince myself that the disease was specific in its origin, especially as it disappeared spontaneously in a short time.

But a little later he began to suffer from nodes, and then the nature of the disease was perfectly plain. Now, gentlemen, had this child not been watched from day to day, the initial lesion of congenital syphilis would have passed unnoticed. I suspect that such was the case with E. H., and also with my other patient whose history is published in the *Photographic Review*.

Some may doubt that these are examples of hereditary syphilis. The only other explanation for the anomaly is to suppose that the disease was acquired by both children. But you will never meet with a more unequivocal history than that of the girl whom I show you this morning; while in the other patient of whom I have spoken, it was as clear as is generally obtained. The direct testimony of the parents is likewise opposed to such a view, for I was not oblivious of these objections when I was examining them.

It seems to me from what I have seen that these mild secondary symptoms are to be met with in those children who are ordinarily said to inherit the disease from their fathers, or whose mothers have passed beyond the second into the third stage of the disease, or in whom the affection has been influenced by treatment, or is for the time arrested. Your attention will be called to this hereafter. The point which I wish to impress upon your minds at present is, that the severity of the secondary stage of inherited syphilis forms no measure by which you can determine what will be the extent of the tertiary lesions. The child who is before you this morning proves this; and I could support the opinion by citing several other striking examples which have fallen under my notice. The most severe bone-lesions may follow the most trivial secondary manifestations. This may probably be partly accounted for by the fact that but few of the infants who have the disease early in life are left without treatment, while a large number of these little patients succumb soon after the affection sets in, so that the treatment prevents these symptoms in the one case, while in the other the child does not live long enough for them to be developed. It is therefore probably those who suffer little or none in early infancy who live to reach the period when the tertiary symptoms manifest themselves.

The patient whom I now have before me furnishes

you with a good representation of the lesions of the third stage of inherited syphilis. You will find these phenomena described by few writers: indeed, the general opinion has seemed to be that these symptoms belong to the acquired disease in adults, and not to the inherited in children.

There is one point upon which I wish to dwell for a moment before leaving the case. This is the course of the nodes when they were situated near large joints. We have had ample opportunity of studying this in our present as well as in some other patients. The danger is that you may mistake this condition for synovitis, especially if the secondary symptoms have passed unnoticed, and this is the initial bone-lesion of the third stage of the disease. I have seen this error committed in one instance. This occurred when the node developed upon the lower end of the humerus. The patient, after a few days of complaint and inability to move the arm, had swelling of the elbow, accompanied by some synovial effusion. It is when the child is first seen at this stage that the error in diagnosis is most likely to be made; but you will be able to arrive at the truth if you examine the joint carefully, and, above all, if you feel the node upon the epiphysis; for it was in this part that the disease was located in the children of whom I have spoken.

In this girl, the disease of the pharynx and nares is sufficiently well marked. This is entirely different from the coryza to which I directed your attention when the first patient was in the room. That was a secondary, and this is a tertiary lesion. That was probably due to simple erythema or mucous patches upon the Schneiderian mucous membrane, while this, appearing as it has done simultaneously with the nodes in various parts of the body, is likely to be owing to disease of the bones of the nose. The fetor and other characters of the discharge support this opinion. I shall not be at all surprised if we have destruction of the hard palate of the child in a short time. This is not a very frequent lesion. Mr. Holmes (*Surg. Treat. of Diseases of Children*, 8vo, Philadelphia, 1869, p. 351) states that he has never met with it in inherited syphilis. I have already alluded to a case which I have recorded, in which there was an orifice an inch long by half an inch wide, in the roof of

the mouth; and I have, at this moment, a child aged about eleven years under my care who has inherited constitutional syphilis, and who has nodes upon her forearms, tibia, and sternum. At the same time, she is suffering from caries of the hard palate; though this has not progressed very far.

Before dismissing this patient, I ask you to notice the condition of her eyes. As you have heard, the right one was accidentally destroyed in infancy. The other remained healthy until nearly a year ago, when she had an attack of interstitial keratitis. This gradually improved, but it has left the cornea somewhat hazy, so that its appearance resembles ground glass. I call your attention to this, so that you may note the results in certain cases of interstitial keratitis, which is an important ophthalmic lesion of inherited syphilis. I fortunately have the opportunity of showing you examples of the disease in its active stage.

*Case III.—Inherited Syphilis; Interstitial Keratitis; Idiocy.*—J. K., æt.  $6\frac{1}{2}$  years, came under observation two years ago with a copious specific eruption and mucous patches. These in a great measure disappeared under the use of antisyphilitic remedies continued for some time, but for more than a year she has been taking no medicine. For some weeks she has suffered from irritability of the eyes, though she has shown but little disposition to avoid the light. Upon inspection, a small white spot, unattended by ulceration, is to be seen near the centre of the left cornea. There is no congestion around that structure. In the right eye, the disease has extended further, so that almost the whole cornea has become opaque, and has the appearance of ground glass, while around it is a well-defined but narrow zone of injected vessels.

This, gentlemen, is a fair representation of the earlier stages of interstitial keratitis, but in some instances the disease progresses further than in this child, as it has done in the boy whom I shall now show you.

*Case IV.—Inherited Syphilis; Interstitial Keratitis following Nodes; Idiocy.*—P. K., æt.  $8\frac{1}{2}$  years, has been under observation for two years. He is the brother of J. K., and, like her, he is decidedly idiotic. When first seen, he was suffering from a squamous syphilide and mucous patches, which disappeared under the use of specific remedies continued for several months. In May, 1871, he had a node on the left humerus, which caused him much pain, and finally yielded to iodide of

potassium. From then until last fall he continued pretty well. At this time he was found to be suffering with sore eyes. The disease began in the cornea and gradually extended until the whole of both of these structures was involved. The left eye presents the usual ground-glass appearance, and there is an injected zone around the margin of the cornea. In the right eye the margin of the pupil is seen with difficulty through the cornea, which, instead of being non-vascular and white like ground glass, is deeply injected, and of a sort of brick-dust or salmon hue. Vessels can be seen traversing every part of its structure, while around it the tissues are deeply injected. There is no ulceration on any part of it, and the boy does not complain of intolerance of light. His upper central incisor teeth are well formed.

In these two cases, you have examples of two stages of one of the most interesting of the ophthalmic lesions of congenital syphilis. These, like all the other effects of the disease, vary with its stage. You are well aware that during the early part of the secondary stage of the acquired affection in adults, the eye is liable to be attacked by serious inflammations; but the one which is chiefly interesting and important is iritis,—a disease which is by no means analogous to the one which we are now discussing. Iritis, while it sometimes occurs, is quite rare in infantile syphilis, much more so than it is in the acquired disease of adults. On the other hand, the affection of which these two children present examples is, if we may judge by the cases in this hospital, sufficiently common, and is the more interesting because it has no analogue among the symptoms of the acquired affection. Keratitis is an inflammation of the cornea, and was until recently supposed to be scrofulous in its origin. In the last decade, however, Mr. Jonathan Hutchinson described it again, under the name of Interstitial Keratitis, and gave it as his opinion that it never appeared except as the result of inherited syphilis. This statement has been questioned by some eminent authorities, but I know of no reason to doubt the conclusions of Mr. Hutchinson. I have had the opportunity to examine a large number of cases of scrofula in the Children's Department of this hospital, and I have never seen interstitial keratitis associated with other symptoms than those of inherited syphilis.

In the first and the younger of these patients, the

affection has but begun. In the one eye—the left one—you see that there is no manifestation of disease except a small opaque spot in the centre of the cornea. This is the way in which keratitis ordinarily commences. Sometimes the opacities are multiple, and the disease spreads from two or more centres at the same time. The location of these spots, in the beginning, is near the middle and in the substance of the cornea, and they spread from the centre towards the circumference until the whole of the structure, excepting a small circle upon its margin, has become opaque. This condition is already represented in the opposite eye, which presents the characteristic ground-glass appearance of the disease. In addition, I ask you to observe one or two other striking peculiarities of these cases. Neither has any ulceration of the cornea, which is always true in uncomplicated keratitis. You notice, too, that upon a mere ordinary inspection the girl does not seem to suffer much with her eyes, and unless you examined them carefully you might fail to see that they were diseased. They are evidently somewhat irritable, for when she comes into a bright light she makes some effort to protect them; but the irritability is not great, for she never refuses to expose herself to the light in any portion of the ward if curiosity or pleasure tempt her. The same may be said of her brother; and this is true of nearly all cases of interstitial keratitis which I have had the opportunity of observing.

A non-professional person would not suppose the girl to have any disease of the cornea, unless he made a somewhat critical examination. This is due to the fact that there is but little increased vascularity of the other structures of the eye. There is no deeply-injected zone immediately around the cornea, but only a little increase in the vascular supply. This is the usual condition in this disease, and I but describe one of its ordinary characters when I call your attention to this peculiarity. In some instances, however, you will see the inflammation pass beyond this stage, when the eye loses the smooth, slightly-polished, opaque, ground-glass appearance, and the cornea becomes slightly granular and faintly pink instead of white. This condition is illustrated in this boy,—the girl's brother,—whose right eye is injected, red, with the cornea slightly roughened

and salmon-colored, while around it there is an irregular zone of turgid vessels, fringes of which extend into the structure of the almost opaque cornea itself. This is a severe case of syphilitic keratitis, and is a very good illustration of the characters which it sometimes presents when it has been neglected.

I hope you have noticed that in both of these children the inflammation of the cornea is a symmetrical lesion. This is usual; though in the cases which I have seen, the disease was not equally severe in both eyes. It had usually advanced further in one than it had in the other when the patient sought advice. This is due to the fact that, though a symmetrical disease as ordinarily seen, interstitial keratitis usually begins on one side first, and after a short period attacks the other.

Both of these children are over five years old. There is another child in the ward in whom the disease is just setting in as she is entering the twelfth year. Keratitis is a late manifestation of inherited syphilis, and is to be placed in the group of tertiary, rather than secondary, symptoms. You see that in the boy it followed the subsidence of the skin-eruption, while it appeared after a node upon the humerus. In the girl it has preceded any bone-symptoms. In E. H., however, it followed repeated outbreaks of nodes upon the forehead and humerus. In the other case which I alluded to as being at present in the ward, the commencing lesion is associated with tertiary symptoms.

Being a symptom of the last stage of the disease, keratitis is not to be looked for until the patient has passed beyond the period of infancy and entered upon that of childhood or adolescence. It usually occurs between the eighth and the eighteenth year. (*Hutchinson, loc. citat.*)

There is only one other point in connection with these two children to which I wish to direct your attention. It cannot have escaped your notice that they resemble each other in the most striking manner, and I now ask you to notice the fact that they are both idiots. I have for some time had a suspicion that there is a relation between idiocy and congenital syphilis,—that in a given number of syphilitic infants a larger proportion of them will be defective in mental development than among the same number of children not so diseased. I should

not be willing to express a positive opinion upon this subject without having had further opportunities to investigate it. I think, however, that the matter would repay examination.

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## LECTURE II.

**G**ENTLEMEN:—The subject of inherited syphilis engaged our attention when I last had the pleasure of meeting you; and, as that topic was by no means exhausted upon that occasion, I shall return to it this morning. The first case which I have to show you to-day is a very interesting one, because it furnishes a good representation of what is said to be a rare syphilitic lesion.

*Case V.—Inherited Syphilis; Rupial Eruption on the Forearm; Dactylitis Syphilitica.*—Mary W., colored, aged 11 years. Her father is a healthy man. Her mother had no other children. Her mother died when Mary was eight weeks old, and is said to have been intemperate and to have led a loose life. She (the mother) suffered from skin-eruptions before death, but no other account of syphilis could be obtained. During infancy, Mary was a very puny child, but we have no positive information in regard to her condition. When she was two years old, she had an eruption on the skin, which her grandmother says appeared as large red blisters, which afterwards became white and broke, when thick crusts formed over them. When these scabs were removed, there were ulcers beneath them. This eruption became general, and was accompanied by oval, elevated patches about the vulva, which, from the grandmother's description, were mucous patches.

She was first admitted to the hospital in May, 1870. At that time there was some enlargement of the lymphatic glands upon the right side of the neck, while the left shoulder, arm, and forearm were covered by well-developed rupial crusts.

These were the remnants of the skin-disease which appeared when she was two years old.

After remaining in the hospital for nearly a year, she was discharged without being improved. In December, 1871, she was readmitted. Some months before this time (the exact date cannot be determined) some of the fingers on her left hand began to swell, and when she was admitted her middle and ring fingers were much enlarged and very tense. In the

middle finger the induration did not extend beyond the first phalangeal articulation, but it involved this with the proximal phalanx. In the ring finger the induration extended beyond and involved the most of the second phalanx. The swelling was firm, but not painful, and the affected part was not hotter than the surrounding surface. The rupia was gradually extending downward, and she now had a crust upon the back of the hand.

*Present condition, May 29, 1872.*—Upon various parts of the body she presents scars of the previous skin-disease. The angles of the mouth are fissured and puckered. On the left cheek is a large rupial crust. The left forearm and back of the hand are covered with the crusts and cicatrices of rupia. The former are from one inch to two inches in diameter. The proximal phalanges of the middle and little fingers of the left hand, and the phalangeal articulation of the former, are much swollen. This is more manifest upon the dorsal than upon the palmar surface, and the former is broader than the latter. The skin over the affected parts is tense, the folds in it are effaced, and the mobility of these fingers is much impaired. The child does not complain of pain in them. They may be firmly pressed or moved without objection upon her part. There is no crepitation in the movement of the joints. The outlines of the phalanges are defined with difficulty, owing to the firmness and tenseness of the swelling, but they appear to be slightly thickened, though it is evident that the increase in the size of the fingers is mainly due to disease of the tissues between the skin and the bones. The hand applied to these parts detects no elevation of temperature. The ring finger is much shortened, so that its distal extremity reaches just beyond the proximal phalangeal articulation of the middle finger. It is a quarter of an inch shorter than the little finger. This deformity is due to destruction of the whole of the proximal phalanx. The metacarpal extremity of the middle phalanx has been destroyed, as well as a small part of the distal end of the metacarpal bone itself. In consequence, though she retains but little control over it, the mobility of the member is very great. The nails on all the fingers are perfect and healthy.

The bridge of the nose is not depressed. She has commencing interstitial keratitis in one eye. Her teeth are moderately well formed, but the upper central incisors are imperfectly developed and slightly notched.

The symptoms of this patient are minutely described, because the condition of the hand is said to be a rare

one. There can be no doubt that the girl has congenital syphilis, although the history is not positive in regard to it. But, without any direct investigation of this point, I do not hesitate to accept this view of the case, because the teeth are imperfectly developed, and she has commencing interstitial keratitis.

I shall not say anything in regard to the rupial eruption upon the forearm and dorsal surface of the hand, because, striking as this may be, and interesting as it is in connection with the congenital disease, my colleagues of the surgical staff can show you better examples of it in cases of acquired syphilis. But I do direct your especial attention to the appearance of the fingers, the description of which you now have the opportunity of verifying for yourselves. This lesion of the hand is known as dactylitis syphilitica, and occurs in the later stages of both the inherited and the acquired disease. The first description of this curious condition was written by Chassaignac, in 1859; but the most elaborate account of it was published by Dr. R. W. Taylor, of New York, in the *American Journal of Syphilography and Dermatology* for January, 1871. Before that time, only five cases of the disease had been fully described. To this number Dr. Taylor added two others. Since then, Dr. Smith, of Ohio,\* and Dr. Wigglesworth, of Boston,† have each reported a case. Mr. Morgan, of Dublin, in his recent work,‡ describes the affection, and mentions having met with three cases of it.

This girl presents what seem to be the ordinary characters of dactylitis. I call your attention to the fact that the swelling involves but a part of the affected fingers,—that is, the proximal phalanx and its phalangeal articulation. You notice, too, that the swelling of the dorsal is greater than that of the palmar surface of these, so that upon transverse section the cut surface would present an imperfectly triangular outline. From the history which has been read to you, you have learned that the disease of the fingers has existed for some time. She has been quite six months under observation, and we have reason to believe that it had been progressing

\* *American Journal of Syphilography and Dermatology*, Jan. 1872.

† *Ibid.*, April, 1872.

‡ *Practical Lessons in the Nature and Treatment of Contagious Diseases*, London, 1872, p. 231.

for two months before she entered this hospital. In the only other case of syphilitic dactylitis that I have had the opportunity of observing, it has run the same chronic course; and Dr. Taylor likewise speaks of this peculiar chronicity of the disease. Its progress seems to be but little influenced by treatment. Another interesting feature of this case is, that the affection of the fingers seems to produce but little suffering. You see how I handle them, and how little she complains. During the whole of the last six months you would never have known from the child herself that anything was the matter with her hand, though during that time some of the bones of the ring finger were destroyed. The same peculiarities characterized another case of dactylitis, which I shall presently show you.

Some of you, no doubt, suppose that this condition is due to disease of the bones of the fingers, or, in other words, that the child has suffered from nodes of the phalanges. Such is by no means the case. In reading the history I particularly emphasized the statement, that the outlines of the phalanges of the middle and ring fingers could be defined with difficulty, but that the swelling did not appear to be due to any disease of these bones. Dr. Taylor describes two forms of this manifestation of syphilis, one of which seems to begin in the bone and the other in the connective and fibrous tissues of the part. This case appears to belong to the latter class, though, if the truth be told, the two varieties are but stages of the same condition. It seems to be a form of gummy tumor, the morbid material of which is produced in the connective and fibrous tissues of the fingers. In some instances, as in this one, the swelling involves only one phalanx; in others, it affects the whole finger, increasing its size uniformly; while in still others, the swelling is confined to the joints in the early stages of the disease. Nor does dactylitis affect the fingers alone; for it sometimes attacks the toes.

Though the bone may not be involved in the first stages of the disease, dactylitis may lead to its destruction; and indeed it has done so in this girl, for you see that the ring finger is shorter than the little one, that it can be freely moved backwards and forwards, and that it presents a peculiar wrinkled appearance, which is due to destruction of the whole of the proximal and a por-

tion of the metacarpal extremity of the middle phalanx. Precisely the same condition is represented in the next patient, whom I show you as an example of recovery from dactylitis syphilitica.

*Case VI.—Inherited Syphilis; Dactylitis Syphilitica; Hutchinson's Teeth.*—W. H. H., aged 10 years, colored, has been an inmate of the hospital from infancy. Five years ago he suffered severely from nodes on the humerus, ulna, and other parts of the body, with dactylitis, which suppurated after a long period of inactivity, and destroyed the whole of the proximal phalanx of the ring finger on the right hand. The disease is now entirely inactive, but the affected finger is a mere stump, which scarcely reaches the second joint of the little finger.

In both of these children you see that the dactylitis has appeared as one of the late manifestations of inherited syphilis. This is not always true; for Taylor quotes the case of Archambault,—an infant in whom this was one of the early symptoms of the disease. Dr. T. C. Smith since then described a case\* in which dactylitis set in when the infant was only six weeks old. These are probably the only examples of the kind upon record; for Taylor, when he wrote, in January, 1871, believed Archambault's case to be unique.

From what I have said, you have been led to infer that dactylitis syphilitica is a rare affection. This is the opinion of Dr. Taylor; but I may say that my colleague, Dr. Maury, tells me that it is his opinion that Taylor has exaggerated its rarity. Dr. Maury tells me that he has seen a large number of these cases, both among persons having acquired and those having congenital syphilis.\*

While I have this patient in the room, I desire to direct your attention to another symptom of inherited syphilis. It is one which has attracted a good deal of attention recently. If you inspect this boy's mouth, you find that the incisor teeth are imperfectly developed, and that their free extremities are notched, and smaller than the bases of the teeth. To Mr. Hutchinson is due the credit of pointing out the significance of this physical sign. Now, these are not typical examples of Hutchinson's teeth, which, when perfect, are smaller,

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\* Amer. Jour. Syphilog. and Dermatology, Jan. 1872, p. 33.

more notched, and have more contracted crowns than these have. You see, too, that the adjoining teeth of the upper, and the middle ones of the lower jaw, present the same peculiarities in a slight degree; but you must remember that it is not among these that you are to seek for these alterations. Mr. Hutchinson has insisted upon the fact that the permanent central incisors of the upper jaw are the ones which are valuable for diagnosis, and you must further remember that he attaches no importance whatever to the various other irregularities in the position and shape of the teeth, which so often occur. The peculiarities to which I have alluded are important, viz.: First, instead of the free edge of the crown of the tooth being the broader, as it is normally, the widest portion is next the gum. Second, the free margin is notched or crescentic. These teeth are rarely present in more than one of the same family of children, and this is usually the one first born with congenital syphilis.

This symptom is wanting in several of the patients who have been before you. In this one (Case V.), M. W., the teeth are by no means perfect, but the alterations are not characteristic,—only sufficient to arouse suspicion of congenital syphilis. In Case II., E. H., the teeth are likewise imperfect.

While in Case IV., P. K., they are large and well developed, his sister (Case III.) has not yet cast her milk-teeth. From what I show you this morning, you see that there is no uniformity in the presence of Hutchinson's teeth; and, to state briefly my own convictions in regard to the matter, I would say that, so far as my present experience shows, these dental changes, when they are present, are absolutely pathognomonic of congenital syphilis, but that they are often absent. It is another element which will aid you in diagnosis, but which, like all other prominent symptoms of disease, is sometimes unavailable, because it is not present. This last fact is easily accounted for if Mr. Hutchinson's view of its causation is correct. He believes it to be due to inflammation of the alveolar process of the jaw, and, just as it is with iritis, keratitis, and various other conditions, the disease may run its course without the inflammation being developed.

Before dismissing the consideration of the symptoms

of congenital syphilis, I wish to impress upon your minds the fact that the tertiary lesions, of which you have seen such striking examples, are by no means common. It is exceedingly rare for bone-disease to occur during infancy. I have only once met with it in a child under two years old; it was in a boy of about fifteen months.

When Diday published his work upon infantile syphilis (New. Syd. Soc. ed., London, 1859), he stated that there were not upon record more than half a dozen authenticated cases of syphilitic bone-disease in infants. Mr. Hutchinson relates another (*loc. citat.*, p. 185).

There is a question connected with this disease which is very interesting, and at the same time very important in its practical bearings. The first patient whom I showed you undoubtedly inherited syphilis from her mother. The same is true of two others; while the histories of the remainder are indefinite upon this point. In none have we any direct account of the father having transmitted the disease. This in hospital practice is the ordinary history; but you must not accept this as conclusive, for it must be manifest to you that we have to contend with many difficulties in obtaining a correct account of the origin and progress of disease in many of our little patients. Still, I am inclined to believe that the influence of the two parents in the transmission of the affection differs, and I am convinced, from the diverse statements of authors upon this point, that the subject demands reinvestigation. For example, Mr. Hutchinson (*loc. citat.*, p. 208) holds that a child will inherit syphilis in as severe a form from the father as from the mother, and I believe that I am not misstating the truth when I say that this is the opinion of most other authorities. On the other hand, Prof. Boeck (*American Journal of Syphilography and Dermatology*, Jan. 1870, p. 16) states that the disease is rarely, and Mr. Cullerier (*Mém. de la Société de Chirurgie*, tome iv., and *Archives Générales de Méd.*, Sept. 1854) believes that it is never, transmitted from the father to the child. A recent and very able writer on this subject, Mr. Morgan, of Dublin (*Contagious Diseases, etc.*, 12mo, London, 1872), thinks that the influence of the father has been much exaggerated.

I have for some time availed myself of every oppor-

tunity to try to obtain information upon this subject, and, while I may subsequently have to modify my opinions in regard to it, I cannot but believe that the mother is much more likely than the father to transmit syphilis to the children, and that, as Mr. Morgan says, the influence of the father has been exaggerated. On the other hand, I do not want you to understand me as saying, with M. Cullerier, that syphilis cannot be inherited from the father. I cannot at present commit myself to any such doctrine; for I have seen more than one sad instance in which men *seem* to have begotten syphilitic children.

It is important that you should inform yourselves thoroughly upon this subject, for gentlemen who have been relieved of secondary symptoms will hereafter consult you in regard to the propriety of marriage. Every physician with any experience can point to numerous examples of this kind. It becomes you, therefore, to be able to give a reliable opinion in regard to it; and I beg you, I beseech you, gentlemen, to remember that when a man has once had constitutional syphilis, you cannot in the present state of our knowledge say positively that he will not procreate a diseased child, no matter if he seems to have fully recovered. You may feel assured that he probably will not, and, more, you may be certain that the probabilities are reduced to a minimum, but, as we now understand these matters, you are not justified in giving a positive opinion in regard to this subject. If a man has once had constitutional syphilis, we do not doubt that under certain circumstances the poison may be eradicated so far as to prevent his begetting a diseased child; but we have as yet no reliable means of judging when this is the case.

If your opinion be asked upon this important question, it is your duty to give it clearly and truthfully, without regard to the feelings of your patient. It is your duty to yourselves, to your interrogator, and to his prospective children. But when you have told him all this, you have only performed a portion of your work. You have seen only one side of the dark picture. This is a cloud which has no silver lining. Not only is a man who is affected with constitutional syphilis to be told that he may transmit the disease to his children,

but he is likewise to be informed that his wife may contract it from him, or from the child in her womb, and that he may in the future have to bear the terrible trial of seeing her suffer from secondary and tertiary syphilis.

I know that there is not one of you who will not shrink from such a trying position as this is. With a human being before you in whose heart burn the same passions, the same loves and hates, that move you, you will feel tempted to put the case in the most favorable light. But, gentlemen, tell the simple truth, remembering the delicacy of your position and the dignity of your calling, —remembering that in your decision are involved the life and comfort of unborn children, the health and happiness of a woman who is about to give her heart's best treasures into another's keeping.

The study of the etiology, and the laws which govern the transmission, of hereditary syphilis is one of the most interesting and important subjects in connection with the disease. Its elucidation, however, is attended with many difficulties. These are increased by the existing disagreements among surgeons and physicians in regard to the acquired affection. This varies much in different cases, both in severity and the order of succession of symptoms. The severity and type of the disease in the child are no doubt influenced by these circumstances in the parent. They are, we have every reason to believe, as potently influenced by the time which has elapsed after the infection of the parents, or by the treatment to which they have been submitted. Where so many elements enter into the consideration of a question, and where their proper appreciation depends so much upon the judgment of the observer, the subject cannot but be surrounded with many difficulties. These are increased, too, by the moral and social peculiarities of the case. Though the disease has set its stigma upon either the parent or the child, the former will often hesitate a long time before acknowledging the truth in regard to it. A man or a woman who would scorn to tell an untruth in regard to anything else will persist in the most unblushing falsehoods in relation to any sexual disorders. And again, the physician, when he sees the first evidences of syphilis in the child, may sometimes hesitate about making inquiries about its origin, for so marvellously perfect is the assumption of ignorance and

innocence in these cases that if he had not known the parties before, he might hesitate in questioning either parent, for fear of creating domestic difficulty. If any of you ever have such doubts as these, if the surroundings of your patient are such that you have misgivings as to which may be the guilty party, do you quietly bide your time, and satisfy yourselves in the interval with properly treating your patient. The chances are that in a little time a troubled conscience will bring one of the parents to you with some unaccountable story, and it is ten to one that this will be the father.

All of these things, I say, make the subject of the transmission of inherited syphilis a very difficult one for investigation; but the interests at stake are so great that it must ever possess a deep importance for the intelligent physician. I alluded, a moment since, to the influence of the father and the mother in the transmission of the disease, and, if you remember, you were told it was my own opinion that that of the father had been much overrated. At that time I quoted the observations of Prof. Boeck and M. Cullerier in support of this opinion. I desire to say a little more in regard to it before proceeding to the consideration of other matters, though I wish you distinctly to understand that I do not want to lessen the force of the advice which I have before given you. The data upon which the profession bases the opinion that the father may be the source of syphilis in his children do not appear to be small, if one peruses the works of the older authors upon the subject. Some of these cases are related in such a straightforward way that it seems almost impossible to doubt the conclusions which have been drawn from them. One thing is noticeable, however, that the same illustrations have been used over and over again, and the conclusions which have been arrived at have been handed down from one author to another, while few new facts have been added to support them. M. Cullerier's observations, however, have led to original research upon this point. This author reported the cases of two gentlemen who married in the active stage of secondary syphilis. They each had one child, both of whom were healthy, up to the time when last seen, one aged eighteen, and the other fifteen years. M. Nottä (*Archives Générales de Médecine*, March, 1860)

relates the histories of eleven syphilitic fathers who had nineteen children. The wives of three of these were likewise affected. Among the nineteen children only four had inherited syphilis, and these were all the children of the infected mothers. The men whose wives were healthy had fifteen children, the youngest of whom was seven months and the eldest fifteen and a half years old at the time M. Notta wrote.

M. Charrier (*Archives Générales de Médecine*, Sept. 1862) records the histories of fourteen additional children, the offspring of seven fathers. In five instances the father had syphilis and the mother was healthy, in one they were both, and in the other the mother only, was diseased. Of the fourteen children, nine were healthy, and *these were the offspring of infected fathers*. Of one of these the age is not given. Of the others the youngest was eight months, and the eldest six years. Of the five diseased children, three were born to the pair both of whom had secondary syphilis, while the wife whose husband was healthy aborted twice, the foetus being diseased in both cases. To these cases may be added two of my own. The history of the first of these is as follows:

*Case VII.*—A gentleman contracted a chancre six years ago. It was cauterized with nitrate of silver within thirty-six hours after its appearance, and this cauterization was repeated upon two successive occasions, at intervals of twenty-four hours, without any medical advice. He then presented himself to me, and the sore had all the characters of a true Hunterian chancre. It healed soon, and in three months afterwards he had copper-colored, slightly scaly spots upon his forehead, trunk, and extremities. These symptoms were followed by sore throat, when he was at once put upon anti-syphilitic remedies. He soon recovered, and married immediately afterwards. His wife shortly became pregnant, and within a year a child was born, who was healthy until five years of age, when I last heard from it. Immediately after his marriage, this gentleman suffered from a faint eruption upon his skin, and from sore throat, which one of the most eminent syphilographers of this city pronounced to be specific, and upon one occasion since then he was under my care for syphilitic maculae and sore throat, which were relieved by specifics.

This history seems to be a clear one; but the following patient suffered much more severely:

*Case VIII.*—A gentleman contracted syphilis in 1861. He neglected himself, and travelled a long distance before he sought medical advice. In the fall of 1862, he was in a most deplorable condition, being wasted almost to a skeleton, having nodes upon various parts of the body, while the nose and hard palate were entirely destroyed. Under the use of specific remedies he gradually improved; but he was not entirely well until four years later. Six years afterwards he married, and in 1869 I attended his wife, a perfectly healthy woman, in her first and only confinement. This issue, a fine boy, is now nearly three years old, and is perfectly healthy.

To sum up now, gentlemen, we have the histories of twenty-eight children, two from Cullerier, fifteen from Notta, nine from Charrier, and two cases of my own, all of them the offspring of syphilitic men who had married healthy women. Not one of these inherited the disease. This number might be increased by several others, but I forbear, as their histories are not so clear as those which have been related; but, in view of these facts, I ask you if it is any wonder that I feel inclined to doubt the opinions of the eminent authorities who think that the father's influence in the transmission of the disease is as strong as that of the mother.

There is one source of error in estimating the influence of the father. It is now generally acknowledged by syphilographers, and is, I believe, demonstrated beyond possibility of doubt, that secondary syphilis is transmissible from one person to another. Zeissl says he has noticed that "as a rule women whose husbands suffer from latent syphilis lose their blooming health, even if they have never been pregnant or had any miscarriages," and Balfour has put upon record a series of cases of healthy women, the wives of syphilitic husbands, all of whom bore diseased children. All of these wives, however, suffered from undoubted symptoms of secondary syphilis, which manifested striking peculiarities. It was by no means severe, came on shortly after the commencement of pregnancy, and in some disappeared without treatment. One of the most important points connected with this form of the disease is, that it may escape the notice of the physician. Balfour, as you may see by reading his paper in the *Edinburgh Medical Journal* for 1856, vol. ii., attributes these symptoms in the mother to her absorption of the poison

from the foetus; but, so far as I am able to judge, this is not yet proved; and is it not possible that their syphilitic husbands gave them the disease at or near the time of impregnation? The intimacy of marital relations must certainly subject the wife to dangers which arise under no other conditions, and they are so great that I cannot but feel that this source of the mother's contamination has to be eliminated before we can implicitly accept the doctrine that a syphilitic father can transmit the disease to his child. Dr. Van Buren, of New York, has recently recorded a case (*American Journal of Syphilography and Dermatology*, Jan. 1870) which bears upon these observations of Zeissl and Balfour, especially upon those of the former. It is so interesting and important that I cannot forbear giving you an abstract of it. A man had chancres on three separate occasions, the first time in the winter of 1854-55, the last time in the spring of 1857. He never had any secondary symptoms, and married a perfectly healthy woman in August, 1858. In a little more than nine months, their first, and in June, 1860, their second child was born, and neither has presented any evidences of inherited syphilis. Now comes the instructive part of the history. In October, 1860, a little more than two years after their marriage, Dr. Van Buren was consulted on account of certain vague syphilitic symptoms in the wife, while in 1861 the husband had syphilitic retinitis, though no mention is made of previous constitutional manifestations. A third child, born in 1862, showed evidences of inherited syphilis in three weeks; while a fourth, born in October, 1867, escaped.

The two facts in this account, to which I wish to direct your attention, are, that a husband with latent constitutional syphilis of which there had never been any obvious signs, not even of cachexia, communicated the disease to his wife, and that his children did not inherit the disorder until the wife had become diseased. These facts certainly give great force to the remark which I made a few moments since, that the part which the father plays in the transmission of syphilis is very uncertain. The matter must remain undecided until the subject has been re-investigated, and more facts collected from which to draw conclusions.

The cases which I have shown you suggest another

question for our consideration. I cannot doubt that the stage of the syphilis in the mother influences the production, and modifies the severity, of the disease in the child. If you review the histories of two of the patients whom I have shown you, and who are again before you this morning, you will find that an attempt has been made to determine the condition of the mother at the time of conception.

In Case I., J. W., the mother had never had any tertiary symptoms, though the secondary manifestations had been severe. At the time she conceived, the disease was perfectly quiescent, so that during and since her gestation she has considered herself perfectly well. Yet you see that the disease appeared in the child within two weeks after his birth; but I would have you notice that it is not at all severe. In the second patient, E. H., syphilis was inherited from the mother, who at the time of conception was probably between the second and third stages of the acquired disease. I have spoken in these lectures of a child in whom congenital syphilis made its appearance after the end of the first year, and whose mother, during gestation, and for a considerable period before it, had had no acute symptoms, though she was greatly disfigured by tertiary bone-lesions.

These facts show you that the condition of the mother influences the development of syphilis in the child, and, more, a fact which has been questioned by some writers upon this subject, that a woman who has some time before suffered from the last symptoms of the tertiary stage may still endanger the life and happiness of her offspring by its transmission. However, I am not inclined to think that such children will always be contaminated. Now, nearly two years ago there was a woman delivered in the ward who had suffered extremely from constitutional syphilis, but who had had no acute symptoms for at least five years. So serious had the disease been, that her hearing was destroyed, her eyesight impaired, her nose much disfigured, and the hard palate perforated. During her gestation I watched her with much interest, thinking that she would be likely to bear a syphilitic child; but it was born healthy, and continued so until he was eighteen months old, when he died of malignant measles, which was epidemic in the

children's asylum during last winter. The father in this instance was a healthy man.

There is another question connected with the transmission of syphilis from the mother to her child which we may discuss before considering the treatment.

The following is the history of the patient who is now before you:

*Case IX.*—L. A., aged 19, was a perfectly healthy girl until two months before her child was born, which was nine months ago. At this time she contracted chancres. Four months later she had well-developed secondary syphilis. She is now covered with copper-colored blotches, a squamous eruption, and has a sore throat. She has nursed her child until the present time. It was born healthy, and was perfectly well until two weeks ago, when a papular eruption appeared upon its belly, back, buttocks, and thighs. This was dark-colored,—decidedly coppery,—and was attended by a little coryza. There were no other evidences of any disease in the child, who is very lively and very strong.

If you will notice this baby, gentlemen, you will see that she is rather remarkable for development and strength, and that she presents absolutely no evidences of disease besides those which I have mentioned. In this the child furnishes a striking contrast to her mother, whose pale, cachectic, downcast face would soon attract attention, while a very cursory examination would reveal the cause of her difficulty. You would say that a child thus born could hardly escape having syphilis, and possibly some of you feel convinced that this is a specific eruption. If you are, I must tell you that I do not by any means feel sure that you are correct. It is true that this eruption looks as if it were syphilitic. Its color, so far as that is of any value, is suspicious, and its association with coryza still more so; but it is doubtful whether this will not prove an evanescent eruption. This opinion is based upon the fact that the mother did not have constitutional syphilis at the time she conceived. Writers assert that a woman, who contracts the primary disease at or after the seventh month of utero-gestation, will not transmit it to her offspring. Diday (*Infantile Syphilis*, New Syd. Soc. ed., 1869, pp. 30, 31) has collected eleven cases in which the mother was infected during pregnancy, and from the analysis of these he concludes that syphilis contracted by the

mother after the *completion of the seventh month*, has never produced the disease in the child. I am strongly inclined to believe, therefore, that this is not the eruption of congenital syphilis, for, according to the girl's account, pregnancy had advanced fully seven months when she contracted the primary disease.

You see at once the importance of obtaining accurate information upon this point, because, if the opinion expressed by Diday be true, we can without danger give these children to another woman to be wet-nursed,—a consideration of no little importance to them. I am willing to confess, however, that I should hesitate some time before assuming the responsibility of deciding upon such a course.

Another consideration has been pressed upon us by this case, and I have several times asked myself whether it is proper to allow a woman infected as this one was to nurse her own child. Though it escaped unscathed from her womb, I cannot see why she might not give her infant constitutional syphilis. You know, however, that, upon the other hand, it is asserted, by those who hold that the father transmits the disease in the majority of cases, that a woman who has borne a syphilitic child without herself being diseased may nurse it with impunity. This, however, seems to me to go to show that she is herself syphilitic, and not to bear at all upon the decision of the other question.

I have felt the same uncertainty about another patient, who contracted syphilis at the end of the eighth month of her pregnancy. In due season, her child, a healthy infant, was born, and was nursed by her. Except that she suffered somewhat from fissured nipples, everything went well until a month after her confinement, when a syphilitic eruption made its appearance upon her. The question to be decided now is whether the mother shall continue to nurse the child or not. If she does not, it is absolutely necessary to procure another nurse. I cannot convince myself that this can be done without danger to the latter, while I cannot but hope that the child has not yet contracted syphilis, and I fear that if allowed to continue to nurse from its mother's breast, she may transmit the disease to it. This case illustrates one of the most trying circumstances that may arise in connec-

tion with infantile syphilis. I do not know how to advise you; for I do not know what to do myself.\*

*Treatment.*—So much time has been spent in discussing other questions connected with this subject, that we have not much left to devote to the consideration of the treatment. The first of these cases, the infant, shall be at once put upon mercury. This may be used in one of two ways; either by the skin or by the mouth. If the former be preferred, the ordinary mercurial ointment is the preparation to be used, in the way recommended by Sir Benjamin Brodie; that is, by rubbing a small portion into the skin of the belly, knee, or inner side of the thigh. Used in this way, the ointment is somewhat offensive; and upon reading a paper by Mr. Marshall (*Lancet*, May, 1872), upon the oleates of mercury as external applications in disease, it occurred to me that this might prove a very useful method of exhibiting the drug in this disease, especially in those cases in which it does not seem desirable to administer preparations of mercury by the stomach. According to Mr. Marshall, the oleate is cleanly and easily absorbed, which is not true of the officinal ointment, as this is a mere admixture of metallic mercury with lard. You will often find local applications of mercury to be very efficient, but in most cases you can give the medicine by the mouth, when you may employ any of the mild preparations. One of the best is the hydrarg. cum cret., a grain or a grain and a half of which may be given once or twice daily. In this case, the medicine will be given in this way, and we will begin with a grain twice daily. At the same time the child must be carefully watched, and his strength sustained by good food, fresh air, tonics, and, if necessary, by cod-liver oil.

Some authorities oppose the use of mercury in the treatment of this disease, and, indeed, there seems to be a growing and an influential body of physicians who take this ground. On the other hand is an equally strong and intelligent body, who look upon it as the most efficient agent in the management of syphilis. I am perfectly willing to confess that I am old fogy

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\* Shortly after the delivery of this lecture, this child began to suffer from a sore mouth, and a month later was covered with an undoubted syphilitic eruption. In the other infant (Case IX.) the eruption proved evanescent, and now, two months later, it remains well.

enough to administer mercury in these cases, that I am fully convinced of its utility, and that, having tried both methods of treatment, I esteem it more highly than any other single drug for the purpose,—nay, more than any other set of drugs. Mercury seems to be a tonic to these children, and while using it they increase in strength and gain in flesh. While I fully recognize the fact that the mortality among them is very great, circumstances are rarely so desperate that there is not a chance that their condition may be improved: so do not turn away from these little patients with the conclusion that there is no hope for them.

In regard to the other children, their treatment must be different. They have all passed beyond the first into the second stage of hereditary syphilis, and, with a single exception, have, at various periods, taken both the iodide of potassium and the bichloride of mercury. The exception is Case V., M. W., who has been treated with cod-liver oil and arsenic without obtaining the slightest benefit. Those who have used the specific remedies in the ordinary way have always been improved by them, and I have no doubt would be again; but, at the suggestion of my colleague, Dr. Maury, I am going to try hypodermic injections of corrosive sublimate in all of the cases. Some of you, I have no doubt, know that this method of treating constitutional syphilis was proposed a few years ago, but, so far as I am aware, it has been but rarely resorted to in this city. I have had no experience with it whatever, never even having seen a case so treated. I am, therefore, not capable of judging of its merits, but I am somewhat prejudiced against it. The most recent writer upon the subject is Dr. Lewin, whose work upon the treatment of constitutional syphilis is just being republished in this country, and the advance proofs of which I have had an opportunity to examine. Dr. Lewin employs three solutions of the following strength for injections,—three, four, and six grains of the corrosive sublimate to the ounce of water,—and states that if more concentrated than the strongest of these, they often cause intense local inflammation. He generally uses the second solution,—four grains to the ounce. Lewin seems to be well satisfied with the local effects of this injection, for he says, “Out of one thousand of my private patients, only one had a small abscess on the

forearm." In these children we shall use the second solution, and shall administer one-twenty-fourth of a grain of the bichloride daily, and gradually increase the quantity to one-sixteenth, if the children bear it well. Lewin prefers the subscapular and sacral regions for administering the injection. We shall use the former region in all of these cases.

I stated, a moment since, that I had a prejudice against this method of giving corrosive sublimate in congenital syphilis. This is not because I am not a firm believer in the virtues of the hypodermic syringe. Few persons can be more firmly convinced of its great utility. But children like these will resist the use of the instrument, and I fancy that not many days will have passed before they will learn to dread the visits of my resident to the wards. No iodide of potassium will be given for the present, and the only other remedies which will be administered are tonics. This child (Case II., E. H.) is, as you notice, very pale, and anæmic. She shall have the following:

R Ferri pyrophos.,  $\frac{3}{5}$ ss;  
 Acid. phosphor. dil.,  $\frac{3}{5}$ iss;  
 Syrupi,  $\frac{3}{5}$ ss;  
 Aq. aurant. flor.,  $\frac{3}{5}$ iss. M.

A teaspoonful in water after each meal.

The pyrophosphate of iron is given simply because it is a pleasant preparation.

Cases III. and IV. are not anæmic, but are thin and not very strong. They shall both have cod-liver oil, and, as they have never taken it, we will commence with a teaspoonful twice daily,—immediately after breakfast and supper.

The remaining girl (Case V., M. W.) will continue the cod-liver oil, which she has been taking for some time.

